MONTANA MEDICAID CLAIM JUMPER

Volume XIII The Montana Medicaid Newsletter Spring 2001

Consultec Now ACS

In the last issue of the *Claim Jumper* you were informed that Consultec had been purchased in 1999 by Affiliated Computer Services, Inc. (ACS), a computer services and systems company based in Dallas, TX. In an effort to make ACS known throughout the market as "one company," Consultec will now become known as ACS. To ease this transition for you, for a short time we will address ourselves as ACS/Consultec in telephone and written correspondence with you.

Calling Provider Relations

Provider Relations phone representatives are available to assist you from 8 a.m. until 5 p.m. on weekdays. When you call you will be greeted by an automated attendant and will be given four options to choose from. Below is a description of each option and instances when they should be used.

Option 1 should be chosen if you're troubleshooting electronic claims submission issues, checking on the status of a transmission (was the transmission accepted or rejected), or for questions about ACE$. If you are checking to see if a claim you submitted electronically was either paid or denied, then you should pick Option 4.

Option 2 is to be used to check Montana Medicaid, MHSP, and CHIP eligibility for a particular date of service.

Option 3 is for questions relating to Provider Enrollment, such as assistance in completing enrollment applications.

Option 4 is to be used when you're checking on claim status and other routine inquiries.

Provider Fair Invitation Enclosed

Fee Schedules Available from Provider Relations

Fee schedules for most types of providers are updated twice a year, usually in January and July, and are available upon request. You may either call, fax, or mail your request to Provider Relations. As with all written correspondence sent to Provider Relations, please make sure to include your provider number on your fee schedule request so we will be able to send you the fee schedule for your provider type.

Extra! Extra! Read all about it! Check the first page of your Remittance Advice for news that may affect you, such as, policy changes and info regarding claims on your Remittance Advice.

Provider Ownership Information Required Upon Enrollment

In order to be paid for services rendered to individuals who are eligible for Montana Medicaid and Mental Health Services Plan, providers must complete a provider enrollment application. Item 21 of that application asks for ownership information. This information is required by Federal and State regulations to be gathered on providers prior to enrollment. The only providers that do not have to provide ownership information are Public Health Clinics and facilities with a non-profit tax status. However, those providers do need to give the name of a managing employee as a contact. If Item 21 of the provider enrollment application is incomplete or not completed at all, the form will be returned for completion. Enrollment cannot be granted if the required information is not given.

Reporting Changes

As a Montana Medicaid provider, you are required to report, within 30 days, all changes that may affect your provider status. These include, but are not limited to, changes in your physical and/or mailing address. Failure to send us a change of address will result in your missing important mailings, especially your warrants and Remittance Advices. Warrants and Remittance Advices cannot be forwarded by the Post Office. If we receive a mailing or a warrant back from the Post Office because of a problem with the address we have on file for you, your provider number will be put into a temporary termination status. We will then use resources such as directory assistance and the Internet to locate you. You must complete the Change of Address form, along with a W-9 form for physical address change, we send you before you can receive your warrants. If you do not respond with an address correction after we have made several attempts to contact you, your provider number will be placed into a final termination status. It will then be necessary for you to re-enroll to become a provider again.

Other important changes you must report include:

- Name changes
- Telephone and fax number changes
- Change of ownership
- Change of Tax Identification number
- If provider will no longer be submitting claims for reasons such as retirement, closure of practice, etc...
- If your facility or group changes status, such as a clinic group becoming a Rural Health Clinic or a DRG hospital becoming a Critical Access Hospital

Please include your provider number on all written correspondence regarding changes.

Billing tip – If you are submitting a claim for an individual who has insurance primary to Medicaid and/or Medicare and the insurance company and/or Medicare has denied payment, you must attach the Explanation of Benefits (EOB) to the claim. The description of the reason for denial must be also be present. Failure to include this information will result in claim denial.

Recently Released Publications

The following is a list of publications sent out since the release of the last *Claim Jumper*. If you would like extra copies of these publications, please contact ACS/Consultec Provider Relations.

Date	Sent to	Topic
1/26/2001	Mental Health Providers	New definitions of SED and SDMI
2/5/2001	Hospitals, FQHCs, and RHCs	Mass adjustments on lab, imaging, and other diagnostic services
2/6/2001	Hospitals, Physicians, Mid-Level Practitioners, FQHCs, RHCs and Clinics	Mammography Quality Standards Act
2/8/2001	Hospitals	Late charges for outpatient hospital services and DRG version change
2/12/2001	Pharmacies, Prescribers, and Mental Health Centers	MHSP copay and formula changes for pharmacy services
2/14/2001	Hospitals	Partial hospitalization no longer covered under MHSP
2/14/2001	Mental Health Centers, Psychologists, LCSWs, and LCPCs	Case management no longer covered under MHSP
2/15/2001	All Providers	Changes to Medicaid and QMB ID cards
2/22/2001	Partial Hospitalization Providers	Two levels of partial hospitalization
2/23/2001	Residential Treatment Centers, Therapeutic Group Homes, Therapeutic Family Care Providers, and Mental Health Centers	Services no longer a benefit for children eligible only for MHSP
2/28/2001	Hospitals	Prior authorization for out-of-state hospital services and reimbursement changes
2/28/2001	Physicians, Mid-Level Practitioners, FQHCs, RHCs, Dentists, and Podiatrists	Prior authorization for out-of-state hospital services
3/12/2001	RBRVS Providers, Hospitals, RHCs, and FQHCs	CPT-4 coding changes

WHAT ARE CREDIT BALANCES AND HOW CAN THEY BE RESOLVED?

When a provider is in a "Credit Balance," it means that adjustments have been done to claims that have reduced the original payments. This results in the provider owing money to the State of Montana Department of Public Health and Human Services.

Credit Balances are reported in a separate section of the Remittance Advice titled "Credit Balance Claims." Credit balances can be resolved in either of two ways. If you are in a Credit Balance and are still actively submitting claims, you can let the amount you owe be worked off future claims. This is the easiest and least time consuming way. Another option, and one you must use if you will not be submitting more claims, is to send a check for the amount owed payable to DPHHS. This check must be sent to ACS/ Consultec to the attention of Provider Relations Field Representative, P.O. Box 4936, Helena, MT 59604-4936. Please attach a note with your provider number on it that the check is for payment of your Credit Balance. Upon receipt of the check, ACS/Consultec will adjust our records to remove you from the "Credit Balance" status. Your check will then be forwarded to DPHHS.

Providers in a "Credit Balance" status will continue to receive Remittance Advices showing the claims involved in the Credit Balance until the Credit Balance is either paid or worked off through claims submissions.

INFORMATION TELEPHONE NUMBERS

Provider Relations	1-800-624-3958 (Montana Providers) (406) 442-1837 (Helena and Out-of-State Providers) (406) 442-4402 (FAX)		
FAXBACK	1-800-714-0075	AUTOMATED VOICE RESPONSE	1-800-714-0060
Point-of-Sale Help Desk	1-800-365-4944	PASSPORT	1-800-480-6823
Direct Deposit	(406) 444-5283		

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Top Denials Reasons for HCFA Medicare Crossover Claims and How to Avoid Them

Montana Medicaid providers are fortunate to be able to participate in the automatic cross-over process that occurs with the Montana Medicare Part B Carrier. However, this process isn't guaranteed to happen for all claims. This article will address the most common reasons for denials of Medicare crossover claims that are submitted on paper.

The most common reason for denial is that a claim for the exact same service was previously submitted and paid. This occurs most often when a provider's claim does automatically cross-over from Medicare at the same time a paper claim is also submitted by the provider. If you do not see that the claim has crossed over automatically on one of your Medicaid Remittance Advices within up to 45 days after hearing from Medicare, then you should send your claim on paper to Medicaid. Timely working of your Remittance Advice is also key to prevent your submitting a claim you have already received payment on.

Verifying an individual's eligibility for Medicaid prior to providing service is the best way to avoid denials for either no eligibility on file or not eligible on date of service. Requiring patients to present the ID cards up front is the best way to confirm eligibility. If the ID card is not present, you may also use other methods such as Automated Voice Response, FAXBACK, or the Medicaid Eligibility and Payment System web site to verify eligibility.